



## Prevention and Wellness Trust

Ch. 224 of the Acts of 2012

### Prevention and Wellness Sustainability Committee

DPH Lobby 1 Conference Room

February 25<sup>th</sup>, 2016

1:00 PM – 3:00 PM

### Meeting Minutes

---

**Committee Members present:** Jean Zotter, Maddie Ribble, Abigail Armstrong (for Sen. Lewis), Elizabeth Toner (for Sen. Welch), Jeff Stone, Virali Shah (for Rep. Hogan)

**Committee Members absent:** Zachary Crowley (also for Sen. Lewis), Sarah Sabshon (for Rep. Sanchez), Samantha Pskowski (designee for Rep. Hogan), Michael Powell (for Gary Sing)

**Guest panelists:** Meredith Rosenthal (Chan School of Public Health, Public Health Council); Brian Rosman (Health Care For All), Pat Edraos (MassLeague of Community Health Centers)

**DPH Staff present:** Carlene Pavlos, Susan Svencer, Claudia Van Dusen, Liz Moniz, Santhi Hariprasad, Durrell Fox, Gail Hirsch, Ashley Stewart, Alissa Caron

**Others present:** Vaira Harik on phone (Barnstable PWTF), Darlene Blanchett on phone (Berkshires PWTF), Kim Kelly on phone (Berkshires PWTF), Tracy Kennedy on phone (Worcester PWTF); Jennifer Turpel (Manet); Roxanne Reddington-Wilde, Peter Wilner, Victor Shopov

---

**Documents/Presentations used during meeting:** none

---

## Introductions and Overview of Agenda

- Review Agenda
- Sustainability committee has been meeting since Aug. 2015, charged with developing recommendations for sustaining the Prevention and Wellness Trust Fund (PWTF)
- Today's goal: think through sustainability for the Trust through a healthcare policy framework
- Approval of minutes
  - Motion to approve by Maddie Ribble. Second by Jeff Stone. All in favor.

## Introduction to Panel Discussion

- Mr. Ribble poses three questions to panel of experts (who have been briefed on key sustainability aspects of PWTF annual report):
  - What opportunities do they see that can sustain PWTF model in the evolution of the healthcare financing delivery system?
  - Looking at specific interventions, what opportunities are there to sustain them?
  - What seems most promising and timely in interventions? What is next logical step to address goals of PWTF?

## Discussion with Panelists

- Mr. Rosman indicates that success stories are important to demonstrate that PWTF interventions helped recipients get on a healthy path. Stories will help to drive policy decisions.
- ***Mr. Ribble inquires about what those setting policies at health system, insurer level want to see.***
  - Ms. Edraos suggests major payers (managed care organizations/MCOs, etc.) need more than stories, need concrete examples to be swayed by PWTF. Also suggests discussion around sustaining the PWTF model may be more important than around sustaining PWTF as a discreet project.
  - Ms. Rosenthal suggests this discussion is a stakeholder analysis that pushes providers towards global payment and a role in "population health", and that this relationship and others that are more explicit in the delivery system may be worth leveraging to support the work of PWTF in the long-run. Connecting opportunities for health systems to attain other goals to investment in public health is an opportunity. Determination of Need and Community Benefits money are opportunities for public health. Health Policy Commission (HPC), MassHealth - the work they are doing to set up rules for accountable care organizations (ACOs,) medical homes, making participation and support of community based initiatives with clinical linkage, could be natural extension of all of that work. Take advantage of delivery-side trends.
  - Ms. Edraos suggests that when considering sustaining the Trust, distinct public health money, Medicaid is the logical place to link it. But doesn't want to see public-health-community-based things become part of a payment system, they need to remain "softer". Where Medicaid stops, public/private community linkages come in.
  - Mr. Rosman notes there are time (payoff is years from now, why make the investment now?) and space (doing things in community that impact the community but not just *their* patients...why invest in that?) issues for both payers and community-organization groups.
  - Ms. Rosenthal notes that providers are becoming more open to population health contracting, that there will always be a role somewhere but that is has to be for public good, otherwise there are limits on private action.

- Ms. Pavlos comments that a public health goal is for whole financing system to move towards improved population health and less costly health care, and savings go back in to public health.
  - Ms. Edraos notes those savings are contested and that capturing them back is an issue. Suggests perhaps Department of Public Health (DPH) could bring in its own money through a centralized grant program system, rather than discreet programs, and use that consolidated money. Might prevent money from being lost to other programs down the line.
    - Mr. Ribble emphasizes the desire to ensure monetary and time investments in PWTF infrastructure don't disappear.
    - Ms. Rosenthal suggests that perhaps the infrastructure could be sustained but possible in a way that does not fulfill full goals of PWTF.
- ***Mr. Ribble notes that the primary services of PWTF are for individuals or families. Ask panelists if coverage seems feasible for individuals and, if so, by whom?***
  - Mr. Rosman the provider system would support this if someone said it was good for health care and population, but that is a long process.
  - Ms. Edraos notes that patient-directed practices need to be sustained, as it seems unlikely that an MCO would pick up the expense of a referral to an outside organizations (like the YMCA), especially given the time frame of potential outcomes and the impacts on patient relationship. Internal reporting infrastructure and longer-term more speculative reporting are concerning. Pick off easy interventions for coverage that have outcomes and interested payors – such as falls.
    - Ms. Reddington-Wilde adds that legal agreements between health providers and non-health providers will be challenging to get. Bringing together traditional healthcare providers and their finance systems, assumptions about norms and what is doable, with community health not involved in that will require relationship building.
    - Ms. Pavlos posits that PWTF is a laboratory for health care transformation. On-going need to get payer interest and coverage for the easier-to-justify interventions. Asks if there an ongoing need for lab to create space for evidence to transform health care system? Payers may not be interested but legislators are.
      - Mr. Stone asks if there is an overarching working group thinking about real transformative innovations (Community Hospital Acceleration, Revitalization, & Transformation/CHART grants, private insurers).
        - Mr. Rosman notes that some are exploring that but the future is unclear.
        - Ms. Edraos adds that the discussion on medical money only goes so far, difficult to break into private insurance world. Maybe talk to Atrius.
        - Ms. Zotter suggests perhaps Atrius could be a next guest speaker for sustainability committee.
    - Ms. Kelly notes that, in thinking about PWTF as a lab, the new Center for Medicare/Medicaid Services (CMS) grant is pertinent and it looking at 3 tracks, looking at what works and what doesn't work in healthcare transformation. Others are thinking through that, something to consider as each community is in different spot.
    - Mr. Fox adds that there has been great synergy in the strategies of Massachusetts Partnership for Health Promotion and Chronic Disease Prevention's Linkages Communities of Practice in connecting clinical to community, talking with HPC, Medicaid, advocates.

- ***Ms. Zotter notes that MassHealth's focus is linking health to housing and food stamps, for example, not focusing on diseases. Asks how PWTF makes a case to MassHealth around PWTF chronic disease prevention when they are thinking about education, housing, food, etc.***
  - Mr. Rosman notes that MassHealth tends to send people to those services because they don't pay for them, and that our goal is to divert from care of sick people to keeping people healthy.
  - Ms. Edraos adds that the pay-for-service world could put the public health identity in jeopardy. Notes that declaring these services as public and making sure there are sufficient dollars in DPH to keep it that way is important to getting payers to act differently.
  - Mr. Rosman notes that whenever MassHealth pays they get \$.50 from the federal government as a match.
  - Ms. Edraos suggests a Center for Disease Control (CDC)-funded match.
    - Ms. Pavlos replies that a match is happening between CDC and CMS though it doesn't cover the same "buckets" of prevention that PWTF addresses.
    - Mr. Ribble suggests that common thought is that clinical providers have money flowing to community-based providers, potentially for some interventions provided by PWTF, ask if that assumption is correct.
      - Ms. Edraos notes that they are talking about social determinants but it is a difficult budget to handle, but that there will be savings somewhere.
      - Mr. Ribble adds that the framework as its being laid out is consistent with current interventions but wonders about the follow through.
        - Mr. Rosman says MassHealth is trying to discuss this now with current federal administration. Notes that there is room for innovation. Must consider how funds are used if MassHealth absorbs savings. Notes that doubling money on anything is worth it.
    - Ms. Edraos suggests adding DPH funding into your waiver bundle for a match.
      - Ms. Rosenthal think a waiver match may be ambitious but suggests there may be a way to make use of MassHealth activity to fund infrastructure while still preserving public health identity. A sustainable funding stream for DPH seems unlikely.
- ***Ms. Pavlos posits that the public health world spends a lot of time talking about how we spend in clinical setting, not prevention, but there aren't health outcomes to show it. Do legislators believe it?***

Ms. Rosenthal and Mr. Rosman both suggest legislators are not sold on this concept on federal level, and with failure in VT as an example.
- ***Mr. Ribbles asks if the CMS funding opportunity, which is seeking to fund infrastructure not community-based services, might have some opportunity for PWTF.***
  - Ms. Rosenthal suggests this opportunity may be viable combined with the lab idea to sell to legislature, MassHealth, feds may.
- ***Mr. Stone asks if there are any other pots of money to consider for innovation.***
  - Mr. Rosman suggests assessing insurers.
  - Ms. Edraos suggests Center for Medicare Medicaid Innovation (CMMI), which is not a lot of money or a particularly good structure, but may or may not be a continuation for PWTF. Also

suggests insurance companies if the monetary ask is specific. Notes that Medicaid patients tend to stay with providers, unlike patients in private insurance, thus there is less willingness to invest among private insurers. Falls should be easy to sell to insurers. However, that human/social services are hard to sell because impacts are harder to quantify, thus coverage is hard to justify. Notes that occurrences of human/social services can be coded, but not outcomes, as opposed to clinical services which come with an assumption that something good happened as a result of the service. Insurers are focused on do patients stay engaged, what is the patient experience.

- Ms. Pavlos agrees this is an important consideration that DPH data team should consider, as health outcomes related to these services are not captured in electronic health records (EHR) data, but perhaps social ones could be. This could be a selling point for the PWTF-as-a-lab idea.
- Ms. Zotter notes that patient experience measures were not built into PWTF, that evaluation measures are outcomes focused for the most part.
  - Ms. Pavlos adds that a second iteration of PWTF could include more patient experience data that MassHealth and ACO systems would use. Mr. Rosman adds that bi-directionality of e-referral is important and having it collect this patient experience measures.
- ***Ms. Zotter asks the panelists what kind of infrastructure MassHealth is looking for.***
  - Ms. Rosenthal replies referral relationships and protocols around bi-directional communication.
  - Ms. Edraos adds that the variety of patient models is valuable, focused around funding and perhaps less around participants in the long run, though participants will strengthen conversation. It's worth looking into what other prevention and wellness activity is happening beyond this funding construct, even perhaps beyond the four PWTF primary conditions. Boston Health Care for the Homeless is doing interesting work.
- ***Ms. Zotter inquires how mental health fits into public health and, if there is a future Trust, how mental health and its cost drivers would fit in.***
  - Mr. Stone suggests looking at data from CHART grants in hospitals that are coordinating behavioral health services to make them more effective.
  - Ms. Edraos adds that ability to stratify behavioral health in more than one direction and to understand the various cost drivers is important. There is severe persistent mental health, substance use, and behavioral health. Behavioral health is often considered social work, “soft”, so is poorly reimbursed and often handled by social workers, including community health workers (CHW). Patients may not be taking medications or taking care of themselves. Funding streams are so bizarre and DMH money doesn’t go to primary care.
  - Mr. Fox notes that the MA Behavioral Health Partnership, regional behavioral health directors are exploring integration of CHW roles around behavioral health.
    - Mr. Rosman adds that this is a key issue in the development of MassHealth ACOs – behavioral health might still be a carve out.
    - Ms. Reddington-Wilde notes that mental challenges are important from a community-based organization(CBO) perspective, (for example, prevalence of mental health and affordable housing issues coinciding)

- Ms. Rosenthal advises that focusing on highest impact opportunities is key: community/clinical linkages and prevention, as done by CBOs, as financing issues of mental health cannot be fully solved from this perspective.
- ***Mr. Ribble asks if hospitals and insurers paying an assessment counts as Medicaid spending for a federal match.***
  - Mr. Rosman replies that it matters who does the spending, though there is room for negotiation. Must be cost neutral. Normally funding has to be spent on medical care but if its non-medical care for Medicaid members (for example in CBOs), Medicaid permissions can be acquired through a waiver to allow redistribution of funding. But if your money is acquired as a tax on providers and insurers, that could be considered recycling (using Medicaid money as its own match), and Medicaid wants to ensure the state match isn't its recycled Medicaid money.
    - Mr. Rosman advises that a waiver will be submitted soon and that the Obama administration has been generous with many states.
    - Mr. Ribble notes that the underlying logic that the waiver is cost neutral in the long-run from a federal perspective creates a focus on cost savings, and tends to forget about equity and health promotion, which may jeopardize the public health identity.
      - Ms. Rosenthal adds that looking for cost savings is not the primary goal of public health and that primary prevention is expensive because you intervene on entire population and impact a small number.
    - Ms. Edraos adds that perhaps there are external industries who would benefit from this (as they did with clean water and vaccines, for example), an economic argument/driver to incentivize this.
      - Mr. Rosman adds that there are econ benefits to spending more on CHWs than surgeons, for example.
      - Ms. Hariprasad suggests social impact bonds.
        - Ms. Pavlos asks the panelists for their opinion on social impact bonds for this kind of work.
        - Ms. Rosenthal suggests that – given that social impact bonds require an *actual* ROI – it's an interesting proposition, given that showing cost savings to the state as a whole in a 5-year period may be challenging.
        - Ms. Pavlos suggests that if we can capture that idea for investors, why not for public health and Mr. Rosman replies it is challenging because it is a narrow focus.
- ***Discussion of community benefits and Determination of Need (DON) reform***
  - Ms. Rosenthal notes that it is challenging to figure out how to make the DON program protect public health and not just check regulatory boxes
  - Ms. Pavlos adds that there is a “customary contribution” to local public health through the DON program.
  - ***Mr. Ribble asks how we can connect PWTF sustainability and DON funding.***
    - Ms. Rosenthal notes that there is not really a strategic process around DON, that each hospital has a different plan for how the DON money is spent.

- Ms. Pavlos add that work has been done – including a health impact assessment on community health impacts of DON – to develop new guidelines around the community health component around DON. Money can go to any active community coalitions. These are conversations each time a DON comes out. A factor 9 component is a stand-alone, negotiated with a health care process by Bureau of Community Health and Prevention.
  - Ms. Edraos asks what would happen if there was legislation directing this money into a continuing PWTF. She further suggests that this would get a lot of people to the table.
  - Ms. Pavlos notes that there are geographic disparities in amount of money available through DON, places that have not received any DON factor 9 money in 10 years. She asks if we could concentrate that issue, as there is concern with current payment models and how the healthcare system is structured. Providers worry about a new structure because they want that money in their service area.
    - Mr. Stone suggests aggregating it and apportioning it the funding.
      - Ms. Pavlos replies that Factor 9 is voluntary; there is no requirement in regulation, so a lot of negotiation needs to happen.
  - Ms. Edraos suggests prioritizing consideration of this as PWTF seems to have leverage to figure out how to allocate/pre-negotiate a lot of stuff, and that every time DON goes through, we waste time without a good structure.
- ***Ms. Rosenthal advises that some of the most promising ideas discussed today require collaboration and coordination for next steps. She suggests reconsidering the idea of compelling stories, and consideration of PWTF as a lab, and lessons learned. She posits that these considerations are an argument for sustaining at least the infrastructure of PWTF.***
  - Mr. Stone adds that there is value in leveraging the innovation and uniqueness of PWTF.
  - Mr. Rosman further suggests that there is value in providing through ACO structures.
    - Ms. Pavlos replies that MassHealth is looking to Oregon for this.
    - Ms. Rosenthal adds that Oregon got a lot of fed money by promising 2% savings after 5 years on entire Medicaid budget.
  - Ms. Reddington-Wilde asks what our chances are of getting the Medicaid waiver?
    - Ms. Pavlos replies that a waiver is submitted every year; MassHealth is presuming we will get millions from this.
    - Mr. Rosman adds, though, that no one really knows.

## Conclusions from Discussion with Panelists

- ***Mr. Ribble lays out the set of recommendations he has gleaned from the panelists that could be made to the Prevention and Wellness Advisory Board.***
  1. Be skeptical of beautiful MassHealth diagrams, look more carefully.
  2. Don't overlook money, \$.5 federal match per \$1 state Medicaid is driver of decisions.
  3. Think about infrastructure investments from MassHealth
  4. Think about the idea of PWTF acting as a laboratory in the evolution of health care financing.
  5. Don't forget about public health identity and public health need.
  6. Remember that for policy makers of all types, opinion equals fact.
  7. Think about community impacts of money.
  8. There's an important conversation for accessing the waiver that we should be part of.

- Ms. Rosman adds that there is skepticism among payers around cost-savings from these interventions.
  - Ms. Zotter asks why this is the case when there are often studies showing good outcomes (using asthma as an example)
    - Ms. Rosenthal notes that savings for the state/MassHealth is not the same as savings for individual MCOs, using interventions are cost-savings for high-risk individuals as an example.
      - Mr. Rosman adds that there are fears that the researchers are biased.
      - Ms. Reddington-Wilde notes that regulations equalize playing field. For example, payers don't mind not being able to drop people for preexisting conditions as long as everyone has to do it.
- ***Mr. Ribble ask the panels what key things should be in the report***
  - Ms. Rosenthal believes that PWTF can be leverage with MassHealth as it is a prerequisite to support what MassHealth is trying to push providers to do. PWTF will support efforts and test alternative mechanisms for good models for building clinical/community bridges. She also suggests identifying key legislative and regulatory requirements to make PWTF successful. For example, a mandate that all covered providers do X and Y. She also suggests hooking PWTF onto the MassHealth waiver to argue that you have the right to exist.
    - Ms. Rosenthal states that health policy makers will capitate, delegate, walk away.
    - Ms. Pavlos adds that they will also want public health to make sure what they've designed works.
  - Ms. Rosman and Ms. Edraos agree with Ms. Rosenthal's comments.

## Closing

- Mr. Ribble requests a motion to adjourn the meeting. So moved by Ms. Zotter. Second by Mr. Stone. All in favor